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# High Reliability + Value Improvement = Learning Organization

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# High Reliability + Value Improvement = Learning Organization

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SL16

The presenters have  
nothing to disclose.

**#IHIFORUM**



# Reflection & Safety Message



# Session Objectives

- Learn how High Reliability Organization (HRO) and Clinical Value Improvement (CVI) are integral to Providence St. Joseph Health's strategic plan and leadership development
- Identify successful elements and challenges of implementation and spread of our high reliability behaviors
- Demonstrate how HRO behaviors are the foundation for daily improvement across a large organization
- Apply Clinical Value Improvement to enable employees to improve their job, quality, and affordability

# Today's Journey

Approx. Time	Topic
20 min	Objectives, Goals, & Get to Know Each Other
20 min	High Reliability Organization Journey
30 min	Activity: Learning Board
20 min	Clinical Value Improvement Journey
30 min	BREAK
20 min	One Hospital's Story
60 min	Activity: Problem Deep Dive
10 min	Closing

# Getting To Know Us



# Who is Providence St. Joseph Health?

 **51**  
HOSPITALS

 **829**  
CLINICS

 **5m**  
UNIQUE  
PATIENTS  
SERVED

 **16**  
SUPPORTIVE  
HOUSING  
FACILITIES

 **119k**  
CAREGIVERS

 **38k**  
NURSES

 **25k**  
PHYSICIANS

 **2.1m**  
COVERED  
LIVES

 **1.2m**  
HOME HEALTH  
VISITS

 HIGH SCHOOL  
NURSING  
SCHOOLS &  
UNIVERSITY

 **2**  
HEALTH  
PLANS

 **\$1.6b**  
COMMUNITY  
BENEFIT

## States served:

**Alaska**  
**California**  
**Montana**  
**New Mexico**  
**Oregon**  
**Texas**  
**Washington**

 **PROVIDENCE**  
Health & Services

St. Joseph Health 

Covenant Health 

 **FACEY**  
MEDICAL FOUNDATION

 **hoag**

 **KADLEC**

 **SWEDISH**

 **pacific  
medical  
centers**

 **Providence  
St. Joseph Health**

# PSJH Mission, Vision, Values, Promise, & Strategy



## MISSION

As expressions of God's healing love, witnessed through the ministry of Jesus, we are steadfast in serving all, especially those who are poor and vulnerable.



## Vision

Health for a Better World



## Values

Compassion Dignity Justice Excellence Integrity



## Promise

Know Me, Care For Me, Ease My Way



**STRENGTHEN  
THE CORE**



**BE OUR  
COMMUNITIES'  
HEALTH  
PARTNER**



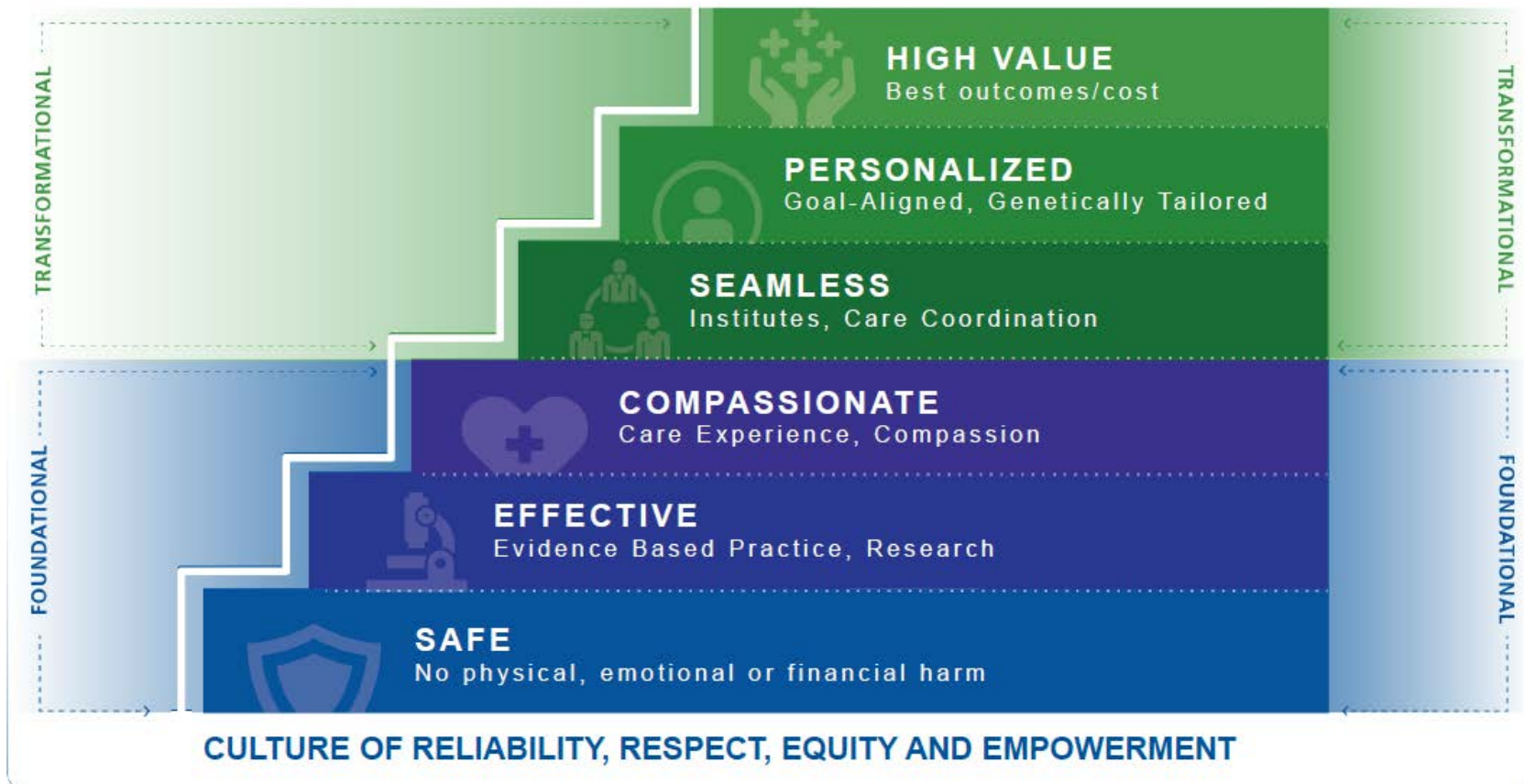
**TRANSFORM  
OUR FUTURE**



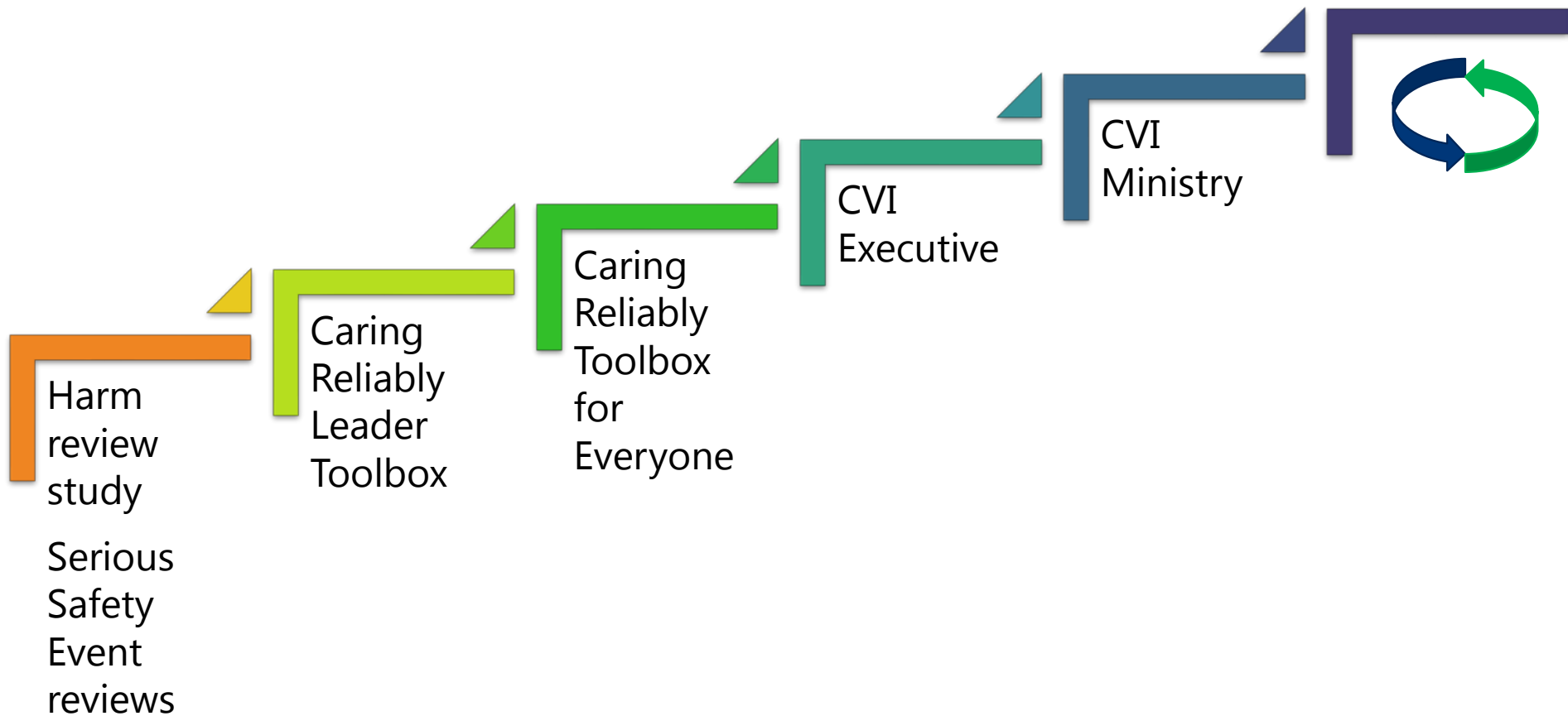
# PSJH Clinical Strategy: HRO is Foundation

KNOW ME  
CARE FOR ME  
EASE MY WAY

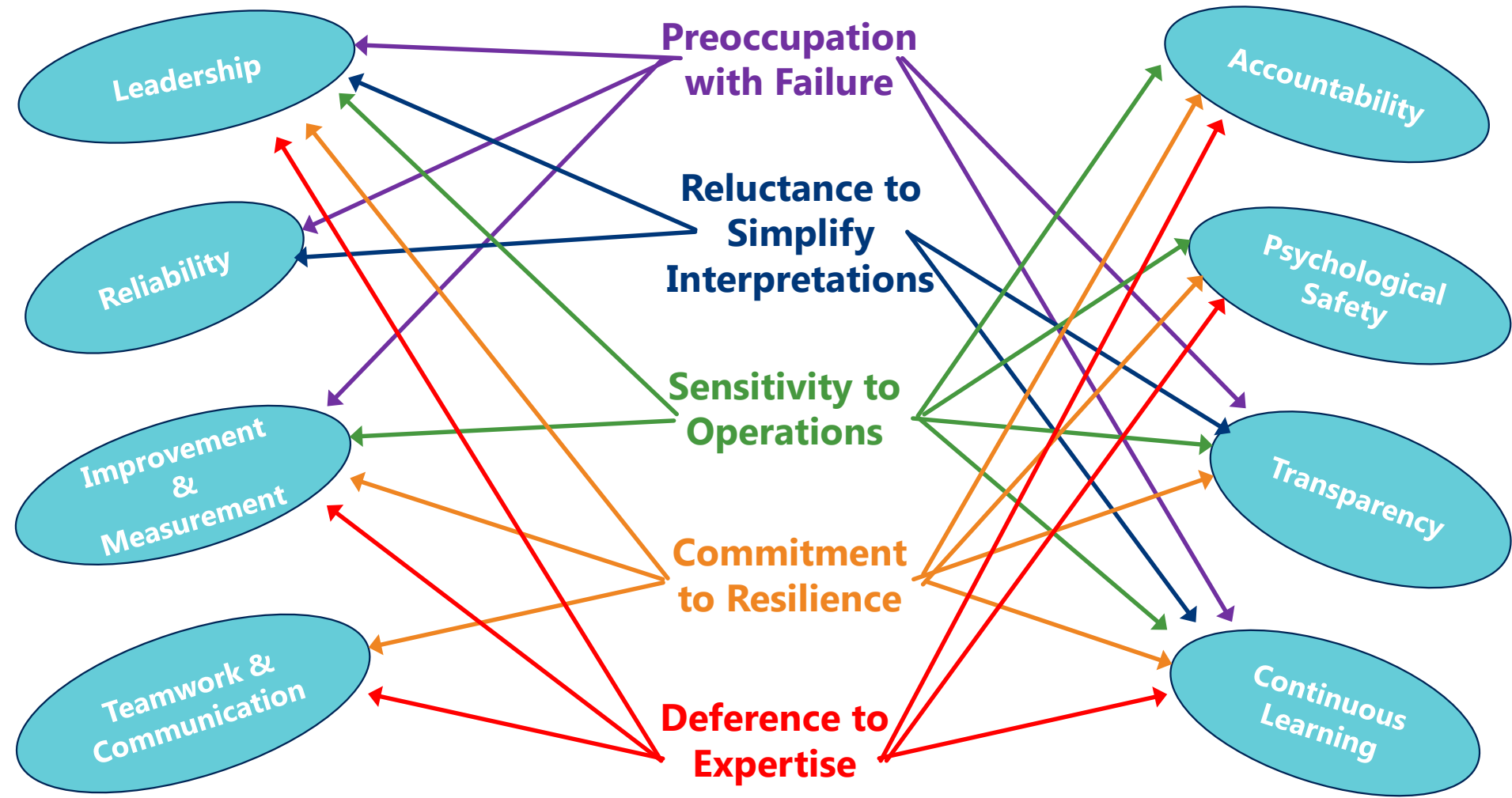
Health for a Better World



# PSJH High Reliability Learning Organization Journey



# How to Achieve Characteristics of HRO

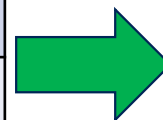


**Sources:** Federico, F (2018). *Is your organization highly reliable?* Healthcare Executive.  
 Frankel A, Haraden C, Federico F, Lenoci-Edwards J. *A Framework for Safe, Reliable, and Effective Care*. White Paper. Cambridge, MA: Institute for Healthcare Improvement and Safe & Reliable Healthcare; 2017. (Available on [ihi.org](http://ihi.org))  
 Wieck, KE., & Sutcliffe, KM. (2007). *Managing the Unexpected: resilient performance in an Age of Uncertainty*. Jossey-Bass.

# Initial Diagnostic Study Summary

## "How" Data: Individual Errors

<b><i>Lack of Critical Thinking</i></b>	<b>37%</b>
<b><i>Lack of Knowledge &amp; Skill</i></b>	<b>19%</b>
<b><i>Lack of Attention on task</i></b>	<b>14%</b>
<b>Non-Compliance</b>	<b>14%</b>
<b><i>Lack of Info processing</i></b>	<b>13%</b>
<b>Normalized Deviance</b>	<b>3%</b>
Moderate to Severe Harm = 785 events Individual Acts coded = 1019	



Toolbox for everyone

With our collective commitment to safety and reliability, we serve our mission and achieve our vision.

**Our Mission**  
As expressions of God's healing love, witnessed through the ministry of Jesus, we are steadfast in serving all, especially those who are poor and vulnerable.

**Our Values**  
Compassion, Dignity, Justice, Excellence, Integrity

**Our Vision**  
Health for a Better World

**Our Promise**  
"Know me, care for me, ease my way."

**CARING RELIABLY**  
Be Compassionate. Be Safe. Be Reliable.

Tones for respect of others at all times

Smile and greet others; say "Hello"

Introduce using preferred names and explain roles

Listen with empathy and intent to understand

Communicate positive intent of our actions

Provide opportunities for others to ask questions

Universal behaviors and tools

**PAY ATTENTION TO DETAIL**

- Self-check using STAR (Stop, Think, Act, Review)
- Peer check

**HAVE A QUESTIONING ATTITUDE**

- Validate and verify
- Know why and comply

**COMMUNICATE CLEARLY**

- SBAR (Situation, Background, Assessment, Recommendation)
- Three-way repeat-back and read-back
- Phonetic and numeric clarification
- Clarifying questions

**OPERATE AS A TEAM**

- Brief, execute and debrief

**SPEAK UP FOR SAFETY**

- Escalation using CUS (Concerned, Uncomfortable, Stop) and chain of command
- Event reporting systems (UOR)

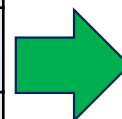
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# Initial Diagnostic Study Summary

## "Why" Data: System Failures allowing errors

<b>Culture</b>	<b>49%</b>
<b>Process</b>	<b>21%</b>
<b>Policy &amp; Protocol</b>	<b>14%</b>
<b>Structure</b>	<b>10%</b>
<b>Technology &amp; Environment</b>	<b>6%</b>
Moderate to Severe Harm = 785 events	
System Failures Acts coded = 1522	



### Leader toolbox

As leaders, we are committed to the safety of our patients and caregivers. We demonstrate this promise in every action, from the front line to the board room.

**Our Mission**  
As expressions of God's healing love, witnessed through the ministry of Jesus, we are steadfast in serving all, especially those who are poor and vulnerable.

**Our Values**  
Compassion, Dignity, Justice, Excellence, Integrity

**Our Vision**  
Health for a Better World

**Our Promise**  
"Know me, care for me, ease my way."

**CARING RELIABLY**  
Be Compassionate. Be Safe. Be Reliable.

Putting our commitment into action

**MESSAGE ON THE MISSION**

- Follow the reflection with a safety message at the start of meetings
- Put safety first in every decision
- Stand up for those who speak up for safety

**LEAD RELIABLE OPERATIONS**

- Hold a daily safety huddle
- Hold daily departmental huddles
- Create and execute on a Top 10 List

**BUILD ENGAGEMENT AND ACCOUNTABILITY**

- Provide 5:1 feedback
- Round to influence
- Apply fair and just accountability principles

**FOSTER TEAMWORK**

- Data boards: unit-based safety, quality and service results
- Operate learning boards
- Create and execute on action plans

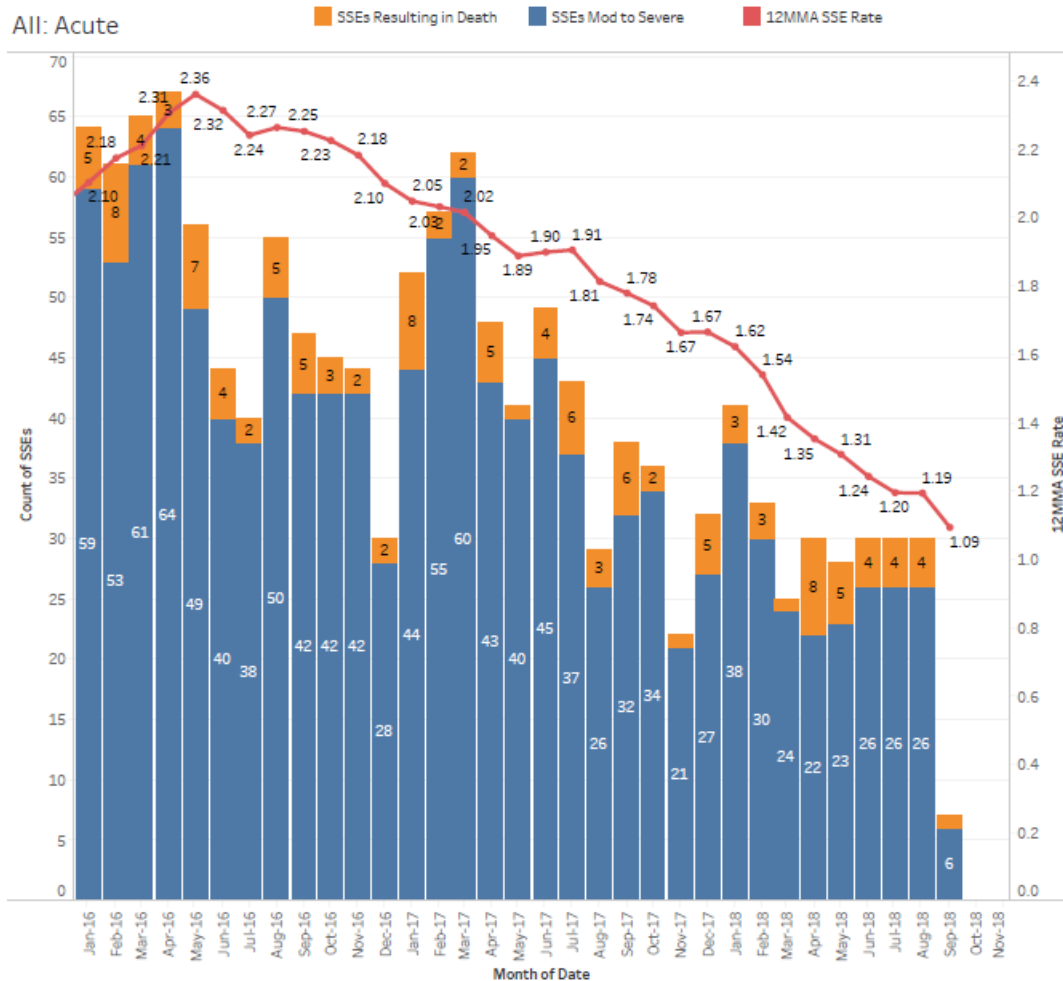
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# Caring Reliably

## Be Compassionate, Be Safe, Be Reliable

### Serious Safety Event Rate: Inpatient only, as of Sept 2018



	Safety Climate all Settings		
	2017 % Favorable	2017 % Positive	% Positive vs. 2016
<b>Legacy PH&amp;S Regions</b>			
AK	80%	74%	+5
NWR	83%	77%	+7
OR	79%	72%	+8
PHC	82%	76%	+5
PMC	80%	74%	+10
PSCS	83%	81%	+6
PSMS	80%	74%	+9
SER	80%	73%	+4
SoCal – LA	81%	76%	+4
Swedish	79%	73%	+5
SWR	78%	70%	+2
VWR	80%	74%	+7
VWR	85%	81%	+8
<b>Legacy SJH Regions</b>			
Northern California	81%	--	N/A
SJH System Office	76%	66%	N/A
SoCal – OC and High Desert	81%	75%	N/A
Texas	81%	78%	N/A
Texas	83%	80%	N/A

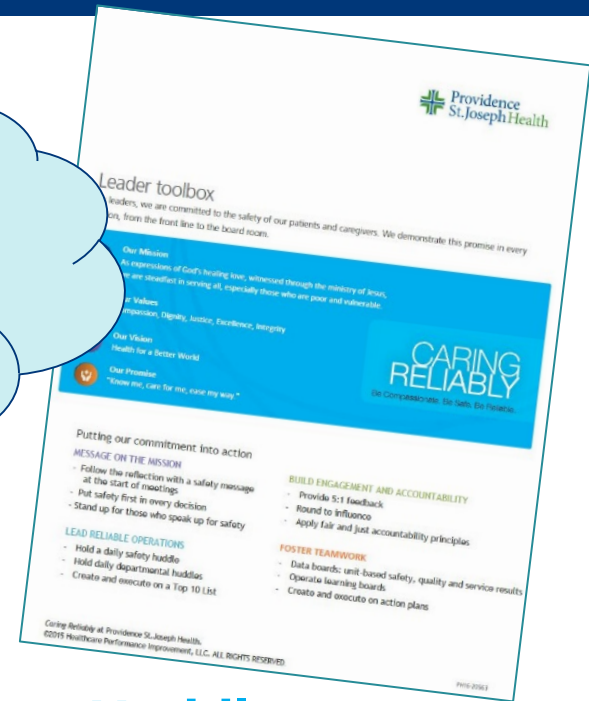
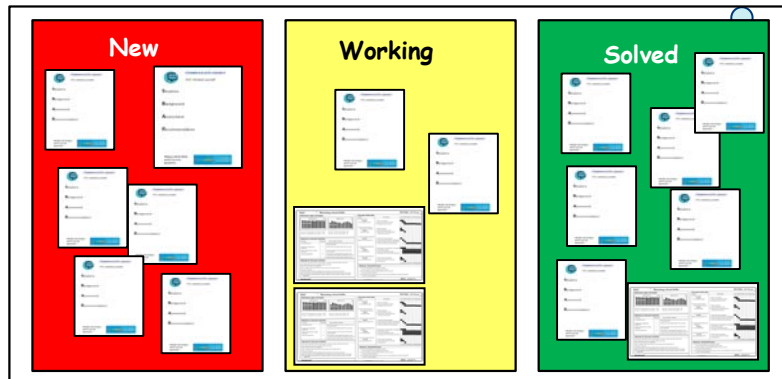


# Building Frontline Ownership

What if I have an idea to improve how we do things???

What if policies, procedures, checklists DON'T MAKE SENSE ???

## Learning Boards



## Department Huddles

### Daily departmental huddle agenda

- 1. LOOK BACK** – Significant safety or quality issues from yesterday
- 2. LOOK AHEAD** – Anticipated safety or quality issues for today
3. Follow up on **Start-the-Clock** Safety Critical Issues

# Two Views of Waste

## Micro

- Overproduction
- Transportation
- Motion
- Waiting
- Processing
- Inventory
- Defects

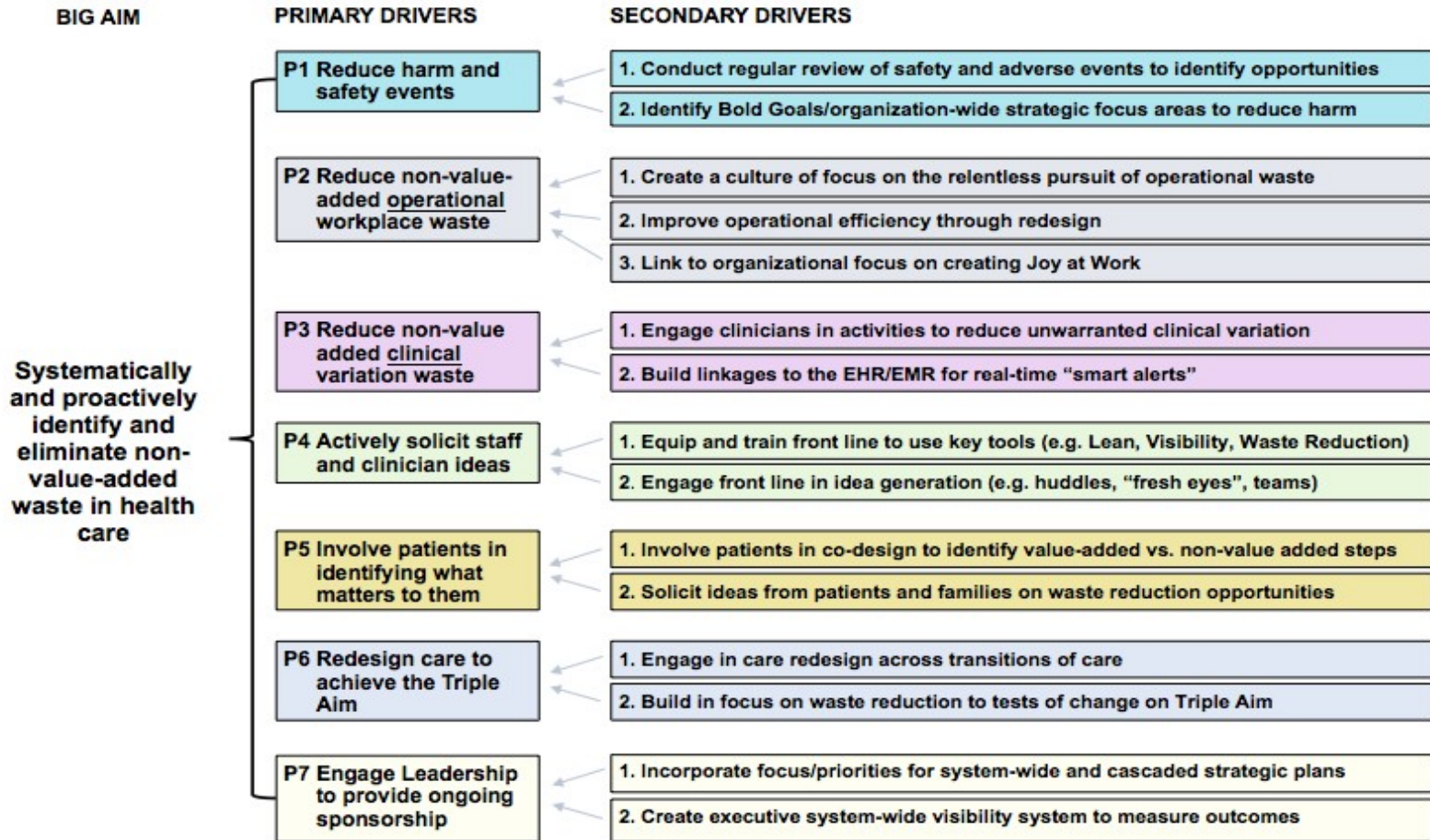
## Macro

- Overtreatment
- Failures of care delivery
- Failures in care coordination
- Administrative complexity
- Pricing failures
- Fraud and abuse

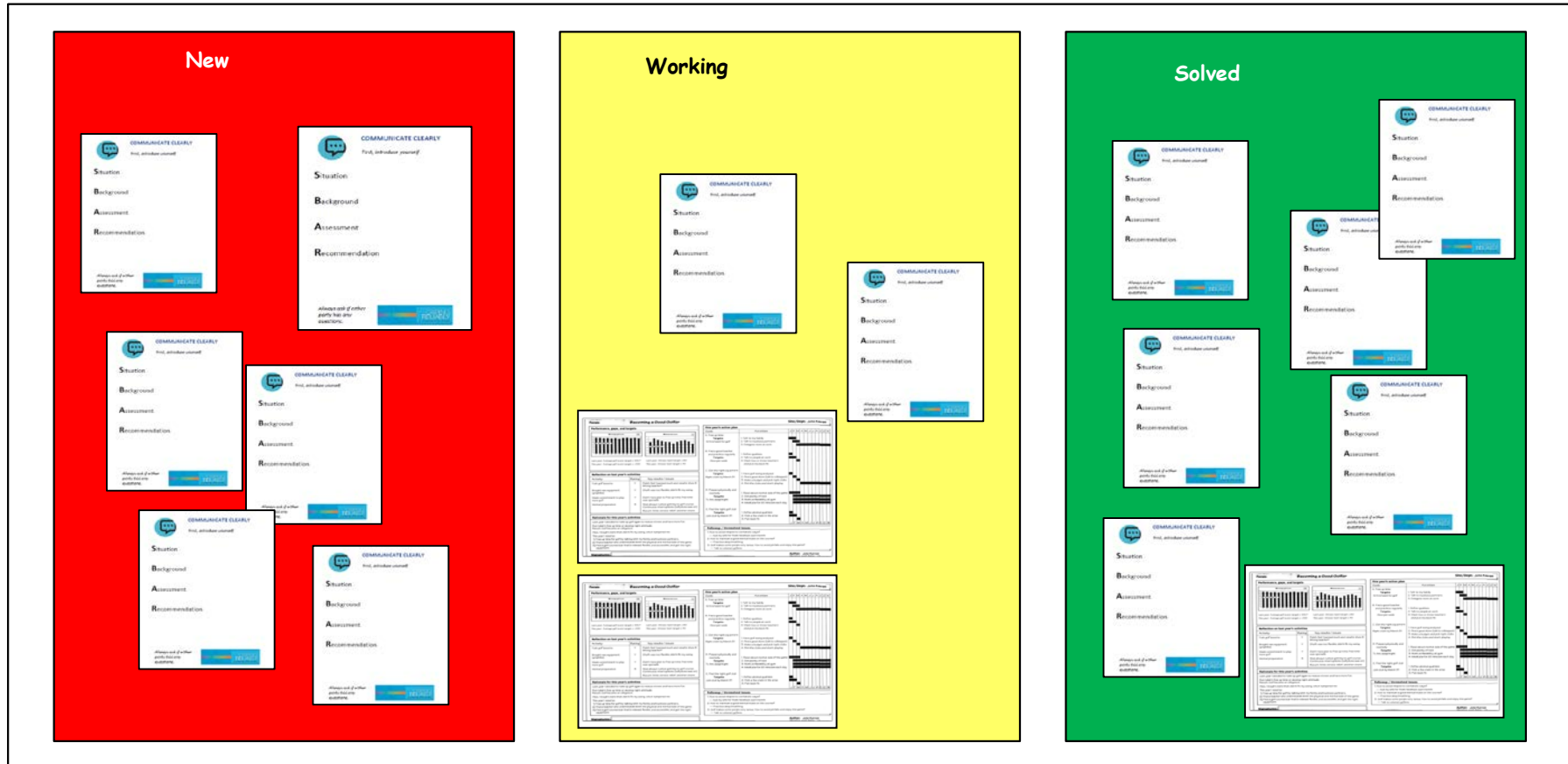
*Source: Berwick, Dm & Hackbarth, AD (2012). Eliminating Waste in US HealthCare. JAMA 307 (14).*



# IHI Leadership Alliance Waste Driver Diagram



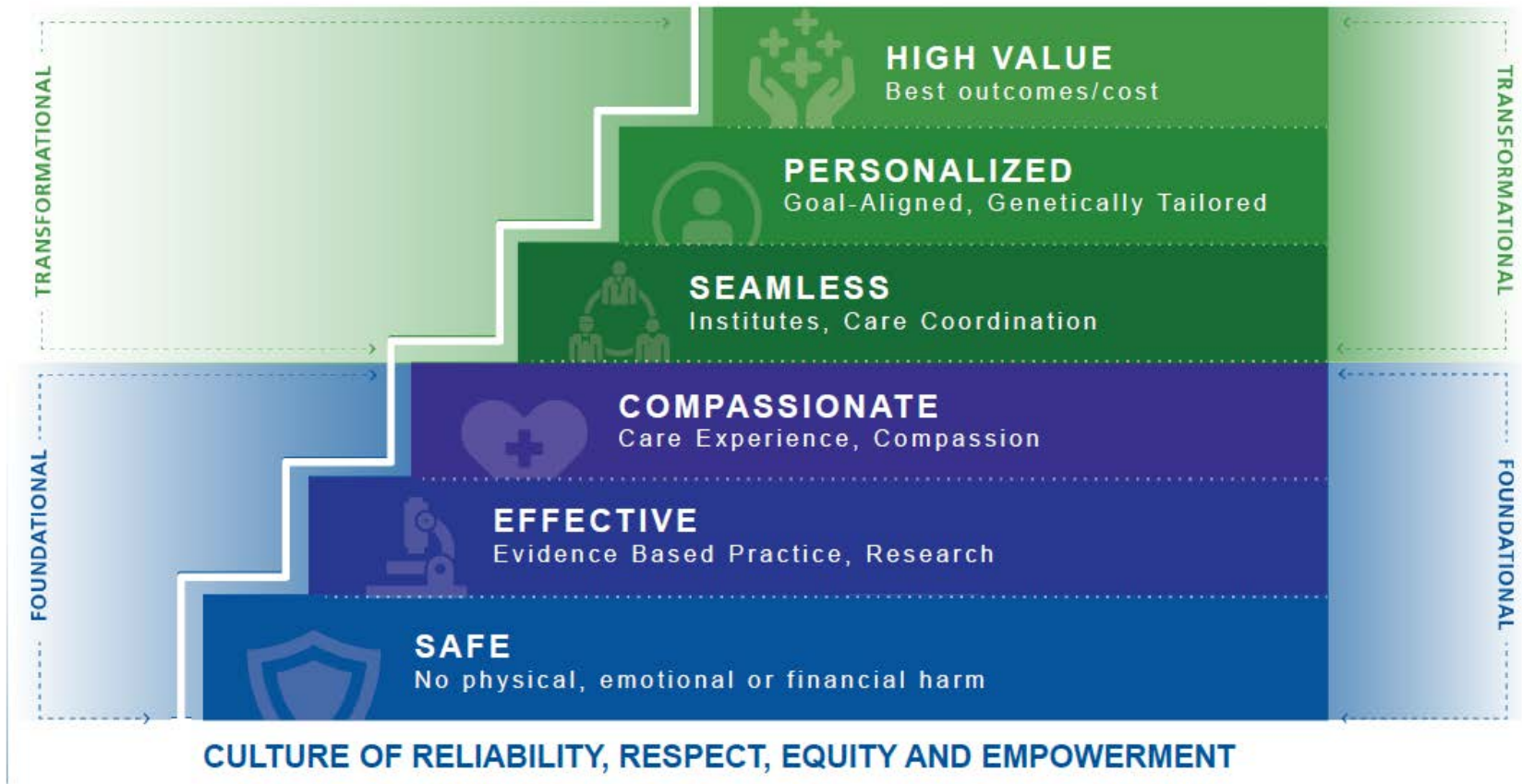
# Simulation: Problem Identification



# PSJH Clinical Strategy: High Value is the Aim

KNOW ME  
CARE FOR ME  
EASE MY WAY

Health for a Better World



# The Value Equation



$$\text{Value} = \text{Outcomes} / \text{Cost}$$

# Develop the Whole Leader





# Clinical Value Improvement | 2018-20 at a glance

**Problem:** We have excellent clinicians in leadership roles, with widely varying leadership skills in **driving value** = a lack of synergy between clinical, operational and financial leaders.

**Vision:** We will develop our executive and mid-level leaders to be the skilled, strategic, transformational leaders we need for **Health for a Better World**

30%

Of healthcare cost is waste JAMA study 2012



\$4.2B

**Aim: 2018-2020**  
Executive & Mid-level leaders

65%

Of our costs come through hospitals



## Clinical Value Improvement

### Executives

- Lead value improvement at micro, meso, and macro levels
- Apply skills of scale, spread, and sustainability
- Set vision of the learning organization in delivering value

### Clinical Directors/Senior Medical Directors

- Statistical process control (run control charts)
- Understanding applying variation in improvement
- Ability to scale & sustain improvements

### Managers/Unit Leaders/Medical Directors

- HRQ Leader Topics
- HRQ Open Source Quality modules
- Coaching for improvement
- Align CVI leader tools into existing practice

### All Caregivers & Providers

- HRQ Toolkit for Everyone
- Eight modules in Healthcare
- AT CUI skills at Hubbers Learning Boards



**Clinical Value Improvement (CVI) Executives;** a project-based, 120 day leadership experience for CMOs, CNOs and CFOs in a Region led by core CVI Faculty.

**Clinical Value Improvement (CVI) Ministry;** a project-based, 85 day leadership experience for Clinical Directors, Unit Leaders and Medical Directors at a PSJH Ministry/hospital led by local faculty.

## Ministry CVI

3 in 2018

30 in 2019

17 in 2020

~1500 leaders

## Executive CVI

1 in 2018; 70 executives;  
70-80 executives in 2019



## 3 types of measures



Behavior

Engagement of medical staff



Results

Progress on Top 20 DRGs

Cost of recruitment



Return On Learning  
Value = outcomes/cost

## How can you help?

Create the time and space for Region CMOs, CNOs and CFOs to engage in Executive CVI



# Clinical Value Improvement

## Tiered Value Improvement Model Vision



# Clinical Value Improvement

## Southern California Executive Program Curriculum



**Learning objectives:** Equip Ministry level CMOs, CNOs and CFOs/COOs to:

- Set the vision of the learning organization to deliver value; craft and lead the strategic improvement agenda
- Ready mid-level leaders to Manage the improvement agenda; coach and train
- Apply skills of scale, spread, and sustainability

### Foundations

What is our aim?

How will we know a change is an improvement?

What changes can we make that will result in improvement?

### Business

What is value?

What are the business drivers of cost?

How do we create and measure value?

### Pebble in the Pond

How can the organization and community structure be used to facilitate spread?

How will I help other leaders inspire organization-wide adoption?



# Clinical Value Improvement

## Southern California Executive Program



**Target Audience: 65 Ministry level CMOs, CNOs, CFOs/COOs, and CQOs**



### Lessons to date:

- **The backstory** = a dynamic, fruitful and sometimes messy endeavor to unify the structure in SoCal
- **The big idea** = to use CVI as a catalyst for coming together as a Region
  - SoCal is in the middle of this journey, and the teams are wrestling with what it means to be “one”
  - It is fragile; and there is a pull towards the local, so CVI is serving as a “proof point”

# BREAK



# Providence Regional Medical Center Everett



## ACCOLADES

2017 Statistics & Awards

- HealthGrades Labor and Delivery, Obstetrics and Gynecology, and Gynecological Surgery Excellence Awards
- US News and World Report – Highest rank in Abdominal Aortic Aneurysm Repair, Aortic Valve Surgery, Heart Bypass Surgery, Hip & Knee Replacement
- Nurse.org – One of the best hospitals for nurses to work
- LifeNet Health – Hospital of the Year
- American Heart Association - Get with the Guidelines Stroke Gold Plus Quality Achievement Award
- CareCheck #1 in Washington State for cardiac care
- Stryker Sustainability Program Gold Healthy Hospital award



340,586

PRIMARY CARE  
OUTPATIENT VISITS



31,150

INPATIENT ADMISSIONS



214,942

SPECIALTY CARE  
OUTPATIENT VISITS



\$65.9  
Million

COMMUNITY BENEFIT



4,540

BIRTHS



89,406

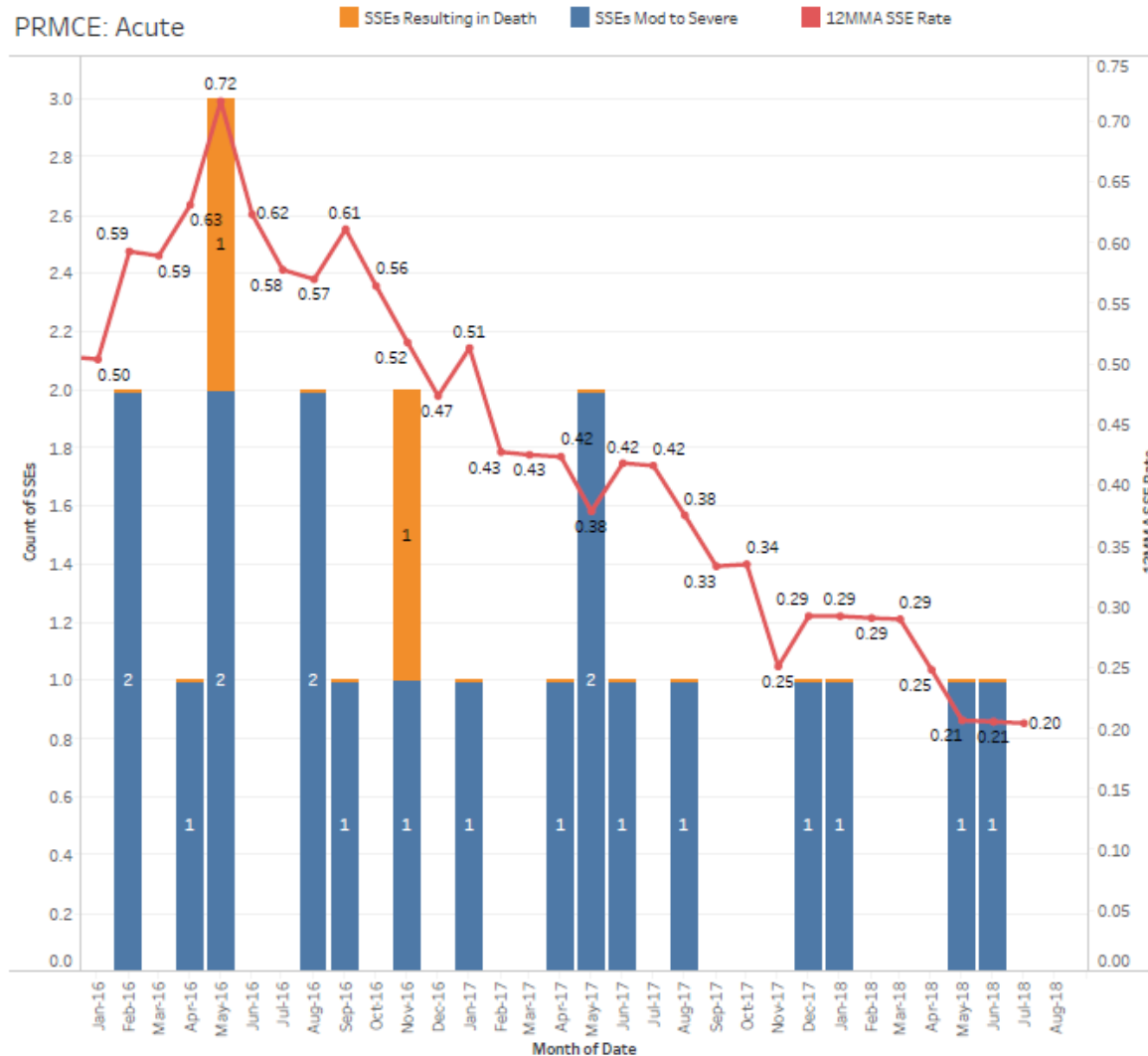
EMERGENCY  
DEPARTMENT  
VISITS



29,750

SURGERIES &  
PROCEDURES

# From HRO to CVI: One Hospital's Story



# One Hospital's Story



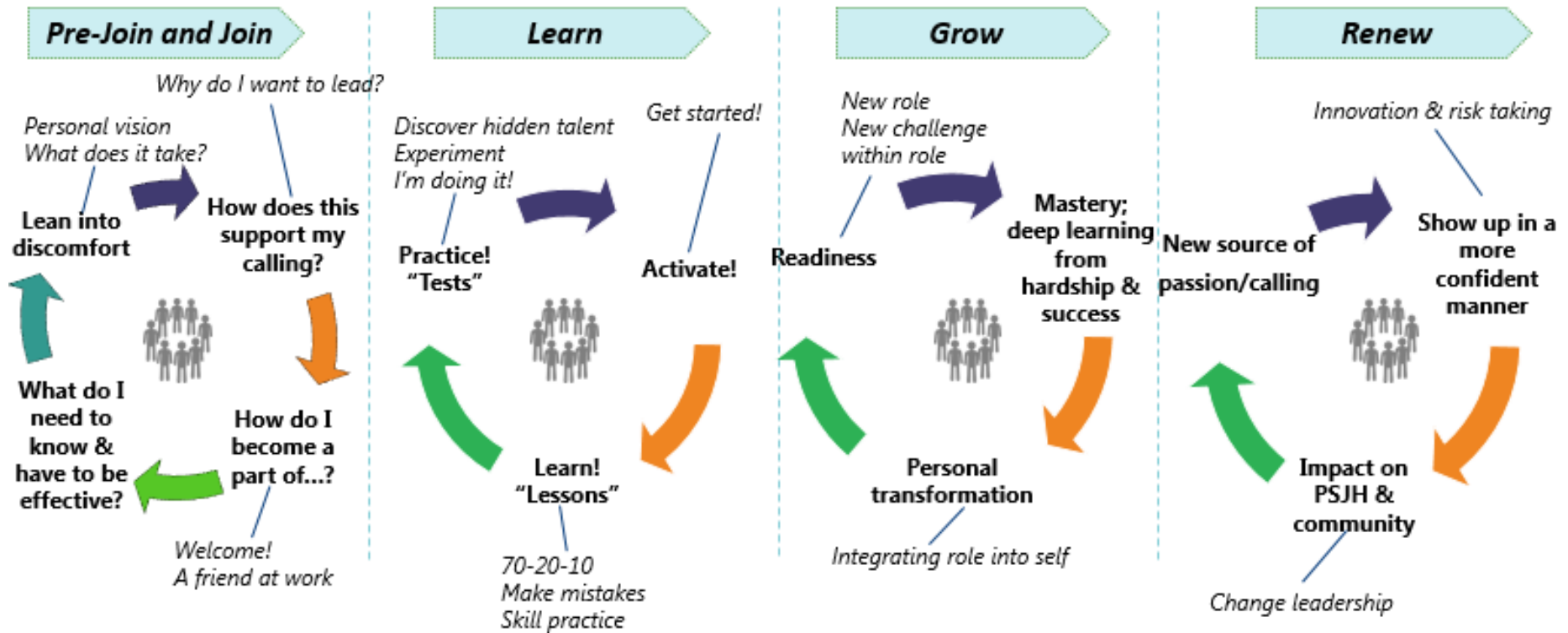
**DIRECT** the **RIDER**  
**MOTIVATE** the **ELEPHANT**  
**SHAPE** the **PATH**

# One Hospital's Story



# CVI Ministry Journey Map

## Clinical Leader: *learning journey*



# Financial Impact of Projects, First Cohort

Hard Dollars  
\$581,887

- Post Partum LOS Reduction \$347,487
- ED Social Admits \$224,000
- Pharmacy Reduction of Wasted IV Meds \$10,400

Soft Dollars  
\$65,170

- Bed Placement Barrier Reduction \$36,340
- Room Readiness (Beds) \$28,830

No Financial  
Impact

- Heart Failure OP Follow Up Appointments
- Inpatient Surgery to Pre-Op Consent Correct
- ED CT Turnaround Time (Closed)



# One Hospital's Story

## Improvement Science

- Use selected IHI Open School modules
- Power of data display on Learning Boards
- Go to gemba

## Finance

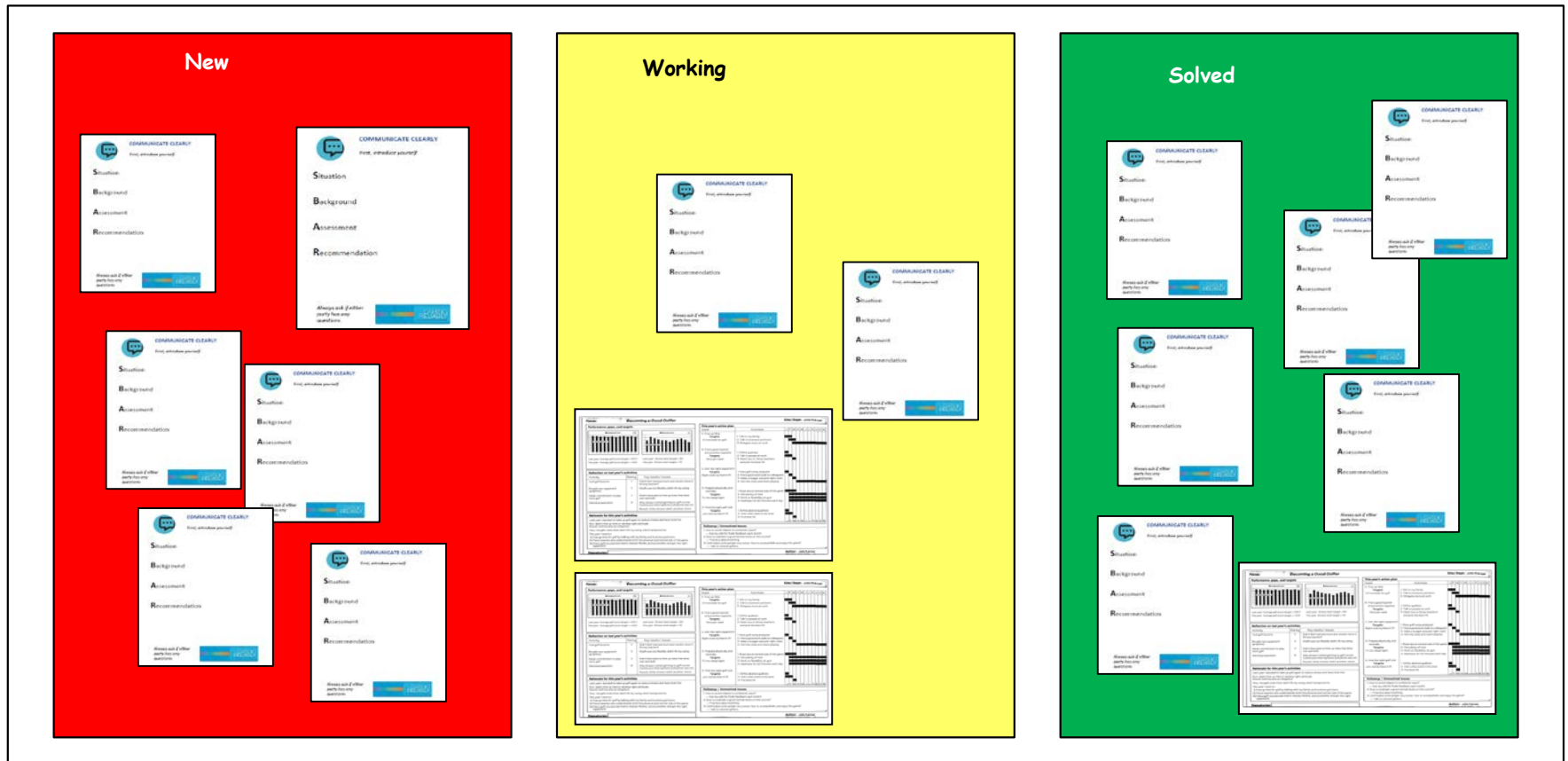
- Partner with CFO early & often
- Insist on ROI estimate at project selection
- Common finance language

## Pebble in the Pond

- Executive Team commitment
- Estimate time commitments with role clarity
- OE partners are vital

# Simulation Work

# Simulation: Problem Deep Dive



# Closing Thoughts

- Evolution of HRO and CVI to address Health for a Better World, must be constantly evolving.
- Breaking silos of where care happens, merging the lines across the care continuum
- Challenge pre-conceived notions that depict how roles traditionally function